UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

EVAN M. JOSEPH,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 4:02 CV 432 DJS
	)	DDN
JO ANNE B. BARNHART, Commissioner of Social Security,	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION
OF UNITED STATES MAGISTRATE JUDGE

This action is before the court for judicial review of the final decision of the defendant Commissioner of Social Security denying plaintiff's applications for disability insurance benefits under Title II of the Social Security Act (the Act), 42 U.S.C. §§ 401, et seq., and supplemental security income (SSI) benefits under Title XVI of the Act, 42 U.S.C. §§ 1381, et seq. The action was referred to the undersigned United States Magistrate Judge for a recommended disposition under 28 U.S.C. § 636(b). The undersigned recommends affirmance.

I. BACKGROUND

A. Administrative record

1. Documentary evidence

On March 16, 2000, plaintiff, who was born in 1976, filed his applications for disability insurance and SSI benefits, alleging a disability onset date of October 27, 1999. In a disability report form, he claimed that his ability to work had been limited since around September 1993 and that he suffered from depression disorder and bulging discs. He maintained that he could not bend or walk without great pain, could not handle the stress of work, and had

panic attacks. He wrote that he became unable to work on October 27, 1999, but had worked until March 8, 2000. Allegedly, he worked fewer hours because of his illnesses, had to change his job tasks, and often needed help from coworkers. (Tr. 93-95, 125, 258.)

On July 9, 1993, neurosurgeon David G. Yingling, M.D., evaluated plaintiff, who had been involved in a motor vehicle accident the previous year. Dr. Yingling noted that plaintiff had right sciatic tenderness but symmetrical deep tendon reflexes, a stable gait, and no tenderness of the lumbar spine to palpation. X-rays of the cervical spine were negative. On July 20, Dr. Yingling reevaluated plaintiff, who brought with him a magnetic resonance imaging (MRI) scan and lumbar spine x-rays. Dr. Yingling stated lumbar spine x-rays showed good alignment of the lumbar vertebra with no evidence of spondylolysis[1] or spondylolisthesis.[2] The MRI revealed some degeneration of the disc at L5-S1 and L4-5 with some mild bulging, but no neural compression. Dr. Yingling prescribed a lumbar brace. (Tr. 161-63.)

Several years later, on June 24, 1999, Dick J. Newell, D.O., examined plaintiff in regard to his back. Dr. Newell found that plaintiff had increased muscle spasm in the T4-T7 areas bilaterally, with decreased flexion of the T spine area; increased muscle spasm in of the LS spine area, with trigger points in the right L2, L3 area; pain radiating into his buttocks and right thigh; and negative leg raising. Dr. Newell performed trigger point injections, showed plaintiff correct lifting form, and told

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[1]"Spondylolysis" is "[d]egeneration of the articulating part of the vertbra." Stedman's Medical Dictionary 1456 (25th ed. 1990).

[2]"Spondylolisthesis" is the "forward movement of . . . one of the lower lumbar vertebrae on the vertebra below it." Stedman's at 1456.

him not to work for at least two days. Lumbar spine x-rays were within normal limits. (Tr. 181-84).

Plaintiff received additional trigger point injections from Dr. Newell in January, February, and March 2000. During the March visit, plaintiff told Dr. Newell that the trigger points worked. (Tr. 185-87, 191-92.)

Plaintiff had been visiting Dr. Jorge Maldonado, a psychiatrist, on a near-monthly basis since January 13, 1999. The treatment lasted for about one year. Dr. Maldonado diagnosed plaintiff with anxiety and a major depressive disorder, counseled plaintiff monthly, and prescribed psychiatric medications. In late October 1999, plaintiff reported to Dr. Maldonado that he was "receiving unemployment" and was going to be assessed for vocation rehabilitation regarding college. On January 3, 2000, Dr. Maldonado stated that plaintiff's diagnosis was major depressive disorder in partial remission. On January 26, the diagnosis also included panic disorder. In February 2000, when plaintiff complained of "side effects" with anti-depression medication Effexor, such as moodiness and headaches, Dr. Maldonado changed plaintiff's medication but noted that the side effects seemed to be a function of depression. He opined that plaintiff's major problem was non-compliance; when plaintiff indicated that he lacked money, Dr. Maldonado gave him samples. (Tr. 167-76.)

Plaintiff's employer sent plaintiff to John T. Blair, M.D., for an examination on March 9, 2000. Dr. Blair stated that a brief neurologic examination was unremarkable and that plaintiff had chronic lower back pain with exacerbation. X-rays of plaintiff's thoracic and lumbosacral spine were within normal limits. Dr. Blair gave pain medication and directed plaintiff to follow up with his regular physician. (Tr. 195, 199, 203.)

John H. True, M.D., performed a consultative examination of plaintiff on March 15, 2000. Neurological examination showed

normal reflexes and sensation in the lower extremities, the ability to heel and toe walk, and the ability to perform straight leg raising to 90 degrees bilaterally without radiculopathy. X-rays of the lumbar spine showed no decrease in disc space, no osteophytes, no increase in pedical distance, and no osteoclastic or osteoblastic activity. Dr. True found plaintiff uncooperative during the examination. Dr. True's assessment was lumbar spondylosis of the low back based on MRI results from 1992, and severe obesity. Dr. True opined that plaintiff was not impaired. (Tr. 177-78.)

Stephen Jordan, Ph.D., examined plaintiff on March 22, 2000, upon referral from the Missouri Division of Vocational Rehabilitation. Plaintiff informed Dr. Jordan that he was currently employed as a laborer, but had re-injured his back on March 9, 2000, and had not worked since then. Dr. Jordan observed that plaintiff exhibited significant pain behaviors. He diagnosed plaintiff with disorders concerning depression, somatoform,[3] written expression, and attention deficit hyperactivity. Dr. Jordan suggested that plaintiff's life is severely constricted by his tension and he many not be able to meet even minimal role expectations without feeling overwhelmed. Plaintiff's Global Assessment of Functioning (GAF) score was 55. As to tests of emotional coping, Dr. Jordan indicated that plaintiff "exhibited either a 'cry for help' profile or symptom magnification." He noted that plaintiff's personality assessment inventory validity scales revealed unusual response sets and that this inconsistency could affect test results. For example, plaintiff gave inconsistent responses to similar items and endorsed items that presented an unfavorable impression. Dr. Jordan raised the possibility of intentional exaggeration of complaints and problems

[3]"[S]omatophrenia" is "a tendency to imagine or exaggerate bodily ills." Stedman's at 1434.

given that patterns of plaintiff's type are relatively infrequent among bona fide clinical patients. While maintaining that this pattern did not necessarily invalidate the test, Dr. Jordan suggested that the interpretive hypotheses may over-represent the extent and degree of plaintiff's pathology. (Tr. 211-17.)

Chinya Murali, M.D., performed a psychiatric examination of plaintiff on April 7, 2000. Plaintiff's GAF score was 60. Dr. Murali diagnosed plaintiff with depression and back problems. He noted that plaintiff walked slowly and slightly bent but had a normal gait. (Tr. 241-42.)

On April 20, 2000, plaintiff returned to Dr. Yingling, who indicated that plaintiff had been doing reasonably well with only some mild aching in his lower back until approximately March 9, 2000, when he developed sudden severe back pain while bending over at work. The doctor stated that plaintiff's lumbar x-rays were unremarkable. His impression was that plaintiff probably had lumbar strain but could have disc herniation, so he referred plaintiff for evaluation by Kenneth Moya, a "pain doctor," and for a lumbar MRI scan. (Tr. 164.)

In May 2000, Dr. Yingling reported that an MRI showed mild dehydration changes of the lower lumbar discs, but no evidence of disc rupture, stenosis, or nerve root compression. Dr. Yingling stated he did not have any surgical options for plaintiff and recommended that he follow-up with his family doctor. (Tr. 165.)

On September 8, 2000, Dr. Rustico Ramos saw plaintiff and noted that it had been recommended that plaintiff take Dilantin for his chronic back pain, but he had stopped taking it. Dr. Ramos found no tenderness to palpation of the LS spine and some paraspinous lumbosacral muscle tightness extending to the upper back. He changed plaintiff's pain medication from Lorcet and Ultram to MS Contin. On September 15, Dr. Ramos received a phone call regarding plaintiff headaches and drowsiness with MS Contin;

however, Dr. Ramos suspected opiate dependancy and refused to prescribe Lorcet.[4] Dr. Ramos saw plaintiff again on September 22 and noted that plaintiff's back pain was improving with MS Contin. He also noted that plaintiff had requested more Lorcet, but the doctor again refused to prescribe it and referred plaintiff to an orthopedist. Noting, on October 9, 2000, that MS Contin was helping plaintiff's chronic low back pain "just a little bit," Dr. Ramos added Vioxx, because plaintiff previously had good results with Vioxx. Dr. Ramos stated that plaintiff had not attended diabetic classes nor did he exercise regularly as recommended, and that his hypertension was stable. Dr. Ramos added that plaintiff's orthopedist would do surgery once plaintiff has lost some weight. Dr. Ramos tried to refer plaintiff to a pain management clinic, but plaintiff simply wanted to go with physical therapy for the time being. (Tr. 246-49.)

In October and again in December 2000, Tim Beyer, D.O., treated plaintiff for anxiety and depression. His most recent progress note states that plaintiff "improved dramatically" with psychiatric medications. (Tr. 255-57.)

2. Plaintiff's testimony

On October 17, 2000, the Administrative Law Judge (ALJ) held a hearing during which plaintiff testified as follows. He graduated from high school in 1995. Thereafter, he held various jobs, none for more than 1.5 years. He began attending a community college in August 2000; he was enrolled in 13 credit hours and attended classes 5 days per week for 2 to 6 hours per day. He became nervous, anxious, and nauseous before tests and had problems with dyslexia, but was able to obtain A and B grades with a tutor's

[4]Lorcet may be habit forming. Physician's Desk Reference 1268 (55th ed. 2001).

help. He suffered from high blood pressure, which was controlled by medication. (Tr. 29, 33-35, 49-50, 56-60, 62-63.)

As to his back, plaintiff testified that he had been diagnosed with two bulging disks and degenerative disk disease, that he had lower back pain for years, and that he suffered from upper back pain since re-injuring his back at work. On a scale of 1 to 10, plaintiff rated his pain level at 5.5. He claimed that his pain could sometimes be lessened by changing the way he would stand, sit, or bend, but that he still felt a constant dull ache and had back trouble every day. He said that he was taking MS Contin, which was not as effective as other medications, but that his doctor did not want to prescribe Loracet. (Tr. 42-44, 47.)

Plaintiff discussed his back pain:

> Q How much can you lift without aggravating your back? Causing it to hurt worse?
> A Just the act of bending causes pain. I don't know I haven't been able to lift my son, you know.
> Q And he's how old?
> A Three years old.
> Q Weighs how much?
> A Forty-six pounds.
> Q Can you lift him?
> A No, I have been able to. When I originally re-injured my back at work I was unable to for approximately two to three months. I was unable to stand, walk, anything.
> Q All right.
> A But I have had some recovery from that.

(Tr. 45.)

As to his capacity to sit without having to stand up, plaintiff stated that he was "pretty much up and down constantly," but that it depended on how and on what he was sitting. To attend the hearing plaintiff drove for 1 hour and 20 minutes without stopping. In addition, he did some housework, cared for his 3-year-old son, occasionally drove 127 miles to visit family members, and shot pool about twice a month, whenever he had the chance to

get out of the house. Plaintiff applied for, and was denied, unemployment compensation after he left Elder Manufacturing, the place where he re-injured his back. (Tr. 36, 46-47, 61, 66-67.)

At the hearing, the ALJ posed a hypothetical question to the vocational expert (VE), which assumed an individual of plaintiff's age, education, and vocational experience, with the residual functional capacity for at least light work exertionally but with restrictions to low stress, simple, repetitive tasks requiring very limited reading. The VE testified that such an individual would be able to perform the light, unskilled job of a packing and filling machine operator and that approximately 3900 such jobs existed in Missouri. (Tr. 71-72.)

B. The ALJ's decision

On February 28, 2001, after considering all of documents identified in the record as exhibits, the testimony at the hearing, and the arguments presented, the ALJ found the following in a ten-page decision. Plaintiff meets the disability insured status requirements of the Act. Although evidence not of record could establish that he engaged in substantial gainful activity since his alleged disability onset date, resolution of that issue is not essential to the decision's outcome. Plaintiff has medically diagnosed mild lumbar disc disease, no-insulin dependent diabetes mellitus, hypertension, dyslexia, attention deficit hyperactivity disorder, a major depressive disorder, and a panic disorder, but "does not have any impairment or combination of impairments which either meets or equals the criteria and severity of any impairment listed at 20 CFR Part 404, Subpart P, Appendix 1." (Tr. 17, 19.)

Next, the ALJ determined that plaintiff's allegations regarding his limitations were not fully credible for the reasons set forth in the body of the decision. One reason was that plaintiff's testimony that he applied for and was denied

unemployment benefits conflicted with evidence that he was collecting unemployment compensation (in October 1999). Further, the ALJ took judicial notice that under state and federal law, persons are not eligible for unemployment compensation unless they certify that they are ready, willing, and able to work, and are actively searching for work. The ALJ did not look favorably on plaintiff's making opposite representations to two agencies at the same time. The ALJ also noted plaintiff's daily activities, including attending college. Additionally, the ALJ noted that, at the hearing, plaintiff did not display outward signs commonly associated with an individual suffering from discomfort, let alone, severe, distracting, and disabling pain. For example, despite testifying that he "is up and down constantly," plaintiff sat throughout the first 48 minutes of the hearing, then stood for 8 minutes before sitting again without displaying any symptoms for the hearing's final 8 minutes. (Tr. 13, 15, 17, 19.)

Moreover, the ALJ noted that plaintiff's medical history was not fully consistent with his alleged symptoms and limitations: there was no evidence of medical treatment or any other event on October 27, 1999, related to the reasons plaintiff was claiming disability; there was evidence that plaintiff worked 5 months after his alleged disability onset date; and clinical examinations and diagnostic testing established no physiologic or anatomical abnormality that could reasonably be expected to produce pain and limitations as severe as alleged. (Tr. 13, 17.)

Next, having "carefully considered all of the medical opinions in the record regarding the severity of [plaintiff's] impairment," the ALJ made the following additional findings. Plaintiff

> retains the [RFC] to perform at least light work, which involves lifting or carrying 20 pounds occasionally and 10 pounds frequently as well as standing/walking, with normal breaks, about 6 hours in an 8-hour workday, and sitting, with normal breaks about 2 hours in an 8-hour

> workday. However, [he] cannot perform the full range of light work because he would be limited to low stress, simple repetitive tasks, as well as limited reading. Additionally, [he] would be moderately limited in his ability to interact appropriately with co-workers.

(Tr. 19.) Plaintiff is unable to perform any of his past relevant work. He is a "younger individual," has a high school degree, and has acquired transferable skills from past relevant work. Based on an exertional capacity for a wide range of light work and on plaintiff's age, education, and experience, and using 20 C.F.R. Pt. 404, Subpt. P, App. 2, Rule 202.22 as a framework, and noting that the vocational expert testified that plaintiff could perform 3900 jobs in Missouri as a packing/filling machine operator, the ALJ concluded that plaintiff is not disabled. (Tr. 20.)

The Appeals Council declined further review. (Tr. 4.) Hence, the ALJ's decision became the final decision of defendant Commissioner subject to judicial review.

II. DISCUSSION

In support of his complaint, plaintiff argues that the ALJ (1) erred by basing the adverse credibility determination on the erroneous belief that plaintiff could lift 46 pounds; (2) erred by requiring objective evidence of pain itself and by not giving appropriate weight to his subjective complaints; and (3) failed to assess the combination of impairments, including mental impairments, from which plaintiff suffered. (Doc. 13.)

The court's role on review is to determine whether the Commissioner's findings are supported by substantial evidence in the record as a whole. See Krogmeier v. Barnhart, 294 F.3d 1019, 1022 (8th Cir. 2002). "Substantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." Id. In determining whether the evidence is substantial, the court

considers evidence that detracts from, as well as supports, the Commissioner's decision. See Prosch v. Apfel, 201 F.3d 1010, 1012 (8th Cir. 2000). So long as substantial evidence supports that decision, the court may not reverse it because substantial evidence exists in the record that would have supported a contrary outcome or because the court would have decided the case differently. See Krogmeier, 294 F.3d at 1022.

A five-step analysis is used for determining disability. See 20 C.F.R. § 404.1520(a)-(f) (2002); Bowen v. Yuckert, 482 U.S. 137, 140-42 (1987) (describing the analysis). "[T]he claimant bears the initial burden to show that he is unable to perform his past relevant work." Frankl v. Shalala, 47 F.3d 935, 937 (8th Cir. 1995). The claimant's burden, if met, shifts to the Commissioner the burden to demonstrate that the claimant retains the physical RFC to perform a significant number of other jobs in the national economy that are consistent with the claimant's impairments and with vocational factors. Id.; see also Singh v. Apfel, 222 F.3d 448, 451 (8th Cir. 2000). The testimony of a VE is required when a claimant has satisfied his initial burden of showing that he is incapable of performing his past relevant work. Hunt v. Massanari, 250 F.3d 622, 625 (8th Cir. 2001).

Taking plaintiff's arguments seriatim, the undersigned believes, first, that the ALJ reasonably interpreted plaintiff's confusing testimony about lifting his son as meaning that plaintiff could lift 46 pounds. In any event, plaintiff overlooks the fact that the ALJ gave multiple reasons for finding plaintiff's allegations less than fully credible, e.g., plaintiff gave inconsistent testimony regarding unemployment benefits, and he did not display outward signs of discomfort and sat for a long time period despite testifying that he was up and down constantly. See Howard v. Commissioner, 276 F.3d 235, 240 (6th Cir. 2002) (plaintiff's inconsistent testimony provided ALJ a reasonable basis

for finding that plaintiff's complaints of pain were less than fully credible); Johnson v. Apfel, 240 F.3d 1145, 1147-48 (8th Cir. 2001) ("The ALJ's personal observations of the claimant's demeanor during the hearing is completely proper in making credibility determinations."); Lowe v. Apfel, 226 F.3d 969, 972 (8th Cir. 2000) (where adequately explained and supported, credibility findings are for ALJ to make). Moreover, inconsistencies between plaintiff's subjective complaints of pain and his daily living patterns, such as regularly attending college, support the ALJ's credibility determination. See Tennant v. Apfel, 224 F.3d 869, 871 (8th Cir. 2000) (per curiam) (it was proper to consider plaintiff's part-time college attendance in assessing credibility determination, as carrying 17 credit hours of classes while maintaining a C average appears inconsistent with allegedly disabling joint pain and fatigue); see also Haley v. Massanari, 258 F.3d 742, 748 (8th Cir. 2001).

Lack of objective findings to support pain is strong evidence of lack of a severe impairment, see Stephens v. Shalala, 50 F.3d 538, 541 (8th Cir. 1995); however, "an ALJ may not discount a claimant's allegations of disabling pain solely because the objective medical evidence does not fully support them," O'Donnell v. Barnhart, 318 F.3d 811, 816-17 (8th Cir. 2003) (emphasis added). Contrary to plaintiff's suggestion, the ALJ did not require objective evidence of pain. In evaluating plaintiff's allegations, the ALJ explicitly acknowledged the need to consider--and did consider--plaintiff's prior work history; daily activities; duration, frequency and intensity of the pain; dosage, effectiveness and side effects of medications; precipitating and aggravating factors; and functional restrictions. See Stephens, 50 F.3d at 541; Polaski v. Heckler, 739 F.2d 1320, 1322 (8th Cir. 1984) (factors for ALJ to consider).

Finally, plaintiff's contention that the ALJ failed to assess the total impact of his impairments in combination is unfounded. In fact, the ALJ stated that plaintiff "does not have any . . . combination of impairments" equivalent to a listed impairment, and additionally acknowledged "the possibility that psychological factors could combine with physical problems."[5] (Tr. 12, 17.) See Hajek v. Shalala, 30 F.3d 89, 92 (8th Cir. 1994) (claimant's argument that the ALJ failed to consider the combined effects of his impairments was unfounded, where the ALJ found a history of several impairments, but that the claimant had not had an impairment or combination meeting or equaling a listed impairment). Although plaintiff wishes more weight had been given to Dr. Jordan's statements, e.g., that plaintiff's life is severely constricted by his tension, plaintiff ignores Dr. Jordan's statement that plaintiff may have exhibited symptom magnification. See Stephens v. Shalala, 50 F.3d 538, 540 (8th Cir. 1995) (addressing malingering). Moreover, "[a] one-time evaluation by a non-treating psychologist is not entitled to controlling weight." Clark v. Apfel, 141 F.3d 1253, 1256 (8th Cir. 1998).

RECOMMENDATION

For the reasons set forth above, it is the recommendation of the undersigned that the decision of the Commissioner of Social Security be affirmed under Sentence 4 of 42 U.S.C. § 405(g).

The parties are advised that they have ten (10) days in which to file written objections to this Report and Recommendation. The failure to file timely written objections may waive the right to appeal issues of fact.

[5]The hypothetical question posed to the VE further indicates that the ALJ considered plaintiff's mental limitations.

DAVID D. NOCE
UNITED STATES MAGISTRATE JUDGE

Signed this _____ day of July, 2003.